Evidence for change of age is shown on FILM No. G 97 AUG 31 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

67929

★ Reg. Dist. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 days

Hospital, institution, or street address where death occurred: Union Hospital

How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

Street No. 104 Church St

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Isabell Adams

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Frank B Adams

6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): Mar. 18 - 1882

8. AGE: Years	Months	Days	If less than one day
61	6	5	4-2 hrs. ... min.

9. Birthplace: Scotland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Wm C. Kelly

13. Birthplace: Scotland

MOTHER — 14. Maiden name: Cora Fraser

15. Birthplace: Scotland

16. Informant: F. B. Adams Husband

Address: 104 Church St - Elkton - Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Aug 20 '45 (month) (day) (year)

Cemetery or crematory: Brookview

Location: Rising Sun Md

18. Funeral director: H W Pippin

Address: Elkton, Md

19. Aug 20 19 45 (Date rec'd by registrar) F R Brazier Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 16 - 1945 at 11.15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 3 - 45 to Aug 16 - 45 and that I last saw h... alive on Aug 16 - 45

Immediate cause of death	DURATION
Cerebral Hemorrhage	9 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: T. H. McKnight M. D. or other

Address: Elkton - Md Date signed: Aug 17-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1192

CERTIFICATE OF DEATH

★ 07930

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Cecil

City or town Port Deposit Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mo.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Cecil

City or town Port Deposit Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Virginia Lee Barton

3. (b) Social Security Number

4. Sex F.

5. Color or race White

6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 23 1945

8. AGE: Years — Months 7 — Days 13 — If less than one day ... hrs. ... min.

9. Birthplace Cecil Co. Md.

(Town, county, and state)

10. Usual occupation Child

11. Industry or business

FATHER 12. Name Robert Barton

13. Birthplace Walden Va.

MOTHER 14. Maiden name Hattie M. Wilson

15. Birthplace Buchanan Va.

16. Informant Robert Barton

Address Port Deposit Md.

17. Burial Date thereof Aug 7 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hopewell

Location near Port Deposit, Md.

18. Funeral director J. E. Tyson

Address Rising Sun Md.

19 Aug 6 19 45 L. M. M. Kimington (?) Registrar

(Date rec'd by registrar)

Permit issued Aug 6 - 45

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 5 19 45, at 9:35 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death Ileo Colitis — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. C. Dodson M.D. Medical Examiner for Cecil County

M. D. or other

Address Rising Sun Md. Date signed 8-5-45

VS A15


RECEIVED
AUG 9 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07931

Reg. Diat. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?:

Hospital, institution, or street address where death occurred: Union Hospital

How long in hospital or institution? 5 minutes.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Dist of Col. County:

City or town: Dist of Columbia

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Charles S Bell.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Lillian Bell

7. Birth date of deceased (mo., day, yr.): Sept 27 1894 6.(c) If alive, give age: 52 years

8. AGE:

Years	Months	Days	If less than one day
50			...hrs. ...min.

9. Birthplace: VA. (Town, county, and state)

10. Usual occupation: Secretary.

11. Industry or business: U.S. Govt.

FATHER

12. Name: Frank B. Bell

13. Birthplace: VA.

MOTHER

14. Maiden name: Fannie Brand.

15. Birthplace: VA.

16. Informant: Maj. Barnes

Address: Ch. Md.

17. Burial + Transportation (Burial, cremation, or removal. Which?) Date thereof: Aug 23/45 (month) (day) (year)

Cemetery or crematory:

Location: Bethesda Md.

18. Funeral director: H. W. Tapman

Address: Elkton, Md.

19. Aug 23 1945 (Date rec'd by registrar) F R Brazier Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 22. 1945 at 1040 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19... to ...19...

and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
Paralysis of Respiration	
Due to: Overdose of	
Due to: Chloral Hydrate	
Self. administered	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 8/22-45

Where did injury occur? Aberdeen. Harford. Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Cots on Barracks 40

Means of injury: Injured at work?

23. SIGNATURE: R L Dodson M.D. Medical Examiner Cecil County

M. D. or other

Address: Rising Sun Md. Date signed: 8-23-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (51-C)

07932

CERTIFICATE OF DEATH

★ Reg. Dist. No. 96

1. PLACE OF DEATH:
County Cecil
City or town Port Deposit Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Cecil
City or town Port Deposit Rural
(If ontside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Haylett Owens Benjamin Sr **3.(b) Social Security Number** 218-03-4432

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Married

8.(b) Name of husband or wife Lillie M. Benjamin 8.(c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Aug 13, 1873

8. AGE: Years 72 Months 1 Days 11 If less than one day hrs. min.

9. Birthplace Leslie Cecil Md. (Town, county, and state)
10. Usual occupation Carpenter
11. Industry or business Construction
FATHER 12. Name George J. Benjamin
13. Birthplace Cecil Co. Md.
MOTHER 14. Maiden name Elizabeth Abrahams
15. Birthplace Cecil Co. Md.
16. Intermant Lillie M. Benjamin
Address Port Deposit, Md. R.D.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 27, 1945 (month) (day) (year)
Cemetery or crematory Rahwell
Location Port Deposit, Md. Rural
18. Funeral director Lee A. Patterson & Son
Address Perryville, Md.
19. Aug 27 1945 Irene E. Dougherty Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24 1945 at 7.50 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1945 to Aug 22 1945
and that I last saw h... alive on Aug 22 1945
Immediate cause of death Carcinoma of Liver — DURATION 1 Month
Due to
Due to
Other conditions Carcinoma of Prostate DURATION 1 1/2 yrs
(Include pregnancy within 3 months of death)
Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE E. D. Brown, M.D. M. D. or other
Address Port Deposit Date signed 8/25/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

07933

CERTIFICATE OF DEATH

Reg. Diat. No. 93

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 79 yrs
Hospital, Institution, or street address where death occurred:
Union Hospital
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No. 131 W Main St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Louisa H Bennett

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widowed

6.(b) Name of husband or wife: Grayson L Bennett
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Apr 2 1866

8. AGE: Years	Months	Days	If less than one day
79	4	4	hrs. min.

9. Birthplace: Elkton Cecil Md
(Town, county, and state)
10. Usual occupation: at Home
11. Industry or business:

FATHER
12. Name: Thomas Heath
13. Birthplace: Elkton Md RD

MOTHER
14. Maiden name: Harriett Bryson
15. Birthplace: Elkton Md RD

16. Informant: Pauline Bennett Kane
Address: Elkton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 16 1945 (month) (day) (year)
Cemetery or crematory: Elkton cemetery
Location: Elkton Md

18. Funeral director: H. W. Pippin
Address: Elkton Md

19. Aug 16 1945 (Date rec'd by registrar) H R Fraser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 13 1945, at 4:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 1945 to Aug 13 1945 and that I last saw h[illegible] alive on Aug 13 1945

Immediate cause of death	DURATION
Abscess Appendicitis	2
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Jas. J. Russum M. D. or other
Address: Elkton Md Date signed: Aug 16 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

07934

Reg. Dist. No. 94

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH

County: Cecil

City or town: North East Rur
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: North East Md
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Margaret Elizabeth Biddle

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: James A Biddle

6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): 12-23-1891

8. AGE:	Years	Months	Days	If less than one day
	53	7	16	...hrs. ...min.

9. Birthplace: North East Cecil Co., Md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: William T. McKinney
13. Birthplace: Md

MOTHER
14. Maiden name: Sarah C Smith
15. Birthplace: Md

16. Informant: Mrs James A Biddle
Address: North East, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 12 1943 (month) (day) (year)

Cemetery or crematory: Methodist

Location: North East, Md

18. Funeral director: Joseph R Thomas

Address: North East Md

19. 8/11 1943 (Date rec'd by registrar) Linda E. Owens Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 12 1943, at 3.09 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 5 1943 to Aug 12 1943 and that I last saw h[illegible] alive on Aug 8, 1943

Immediate cause of death	DURATION
Due to: Carcinoma Left Breast	
Due to:	
Other conditions	

(Include pregnancy within 8 months of death)

Major findings of operation: Carcinoma Left Breast

Date of op. Dec 5 1942

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: [illegible] Cornwell M.D. M. D. or other

Address: North East Md Date signed Aug 10 1943

Evidence for change of age is shown on FILM No. G 97 AUG 31 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

07935

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: Cecil
City or town: Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 Months
Hospital, institution, or street address where death occurred:
Veterans Administration
How long in hospital or institution? 7 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. R. D. # 2
(If rural, give LOCATION)
2.(a) If veteran, name war: World War 1. ✓

3.(a) FULL NAME: BLAIR, Russell S.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Jeannette R. Blair
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 8, 1896

8. AGE: Years	Months	Days	If less than one day
49 ~~51~~	-- 7	~~14~~ 7	..... hrs. ..... min.

9. Birthplace: Clearspring, Md. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:
FATHER 12. Name: William Blair
13. Birthplace: Unknown
MOTHER 14. Maiden name: Florence Shafter
15. Birthplace: Unknown
16. Informant: Hospital Records
Address: Veterans Administration, Perry Point, Md.
17. Removal (Burial, cremation, or removal. Which?) Date thereof 8-16-45 (month) (day) (year)
Cemetery or crematory: Antietam National Cemetery
Location: Sharpsburg, Md.
18. Funeral director: Pennington & Son
Address: Havre de Grace, Md.
19. Aug. 16 1945 (Date rec'd by registrar) Irene E. Doughty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 15 1945, at 1:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 15 1945, to August 15 1945 and that I last saw him alive on August 15 1945

Immediate cause of death ..... DURATION
Disease of the Coronary arteries .....
Due to: Coronary arteriosclerosis — Immediate
Due to: .....
Other Conditions
Other conditions: Psychosis due to alcohol — 4 mo.
(Include pregnancy within 3 months of death)

Major findings of operations: ------
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of .....
Where did injury occur? ----- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work? .....

23. SIGNATURE: A. E. Bradley
Colonel, M.C. Clinical Director M. D. or other
Address: Perry Point, Md. Date signed 8-16-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07936

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 94

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Charlestown, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, institution, or street address where death occured: Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Charlestown, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Frank Chesterman Bratton

3. (b) Social Security Number

4. Sex: M
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Widower
6.(b) Name of husband or wife: Bessie M.
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): June 9 - 1869
8. AGE: Years 76 | Months | Days | If less than one day ... hrs. ... min.
9. Birthplace: Delaware (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: Pennsylvania RR
FATHER 12. Name: Charles Bratton
13. Birthplace: Del
MOTHER 14. Maiden name: Elizabeth Chesterman
15. Birthplace: Pa
16. Informant: Ernest M. Ratledge
Address: Hill Crest Del
17. Burial Date thereof: Aug 9 - 45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Mt Salem
Location: Wilmington Del
18. Funeral director: Marshall H. Yeatman
Address: Wilmd
19. 8/7 1945 Lida V. Owens
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 6 1945, at 10 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ...
and that I last saw h(im) dead on Aug 6 1945

Immediate cause of death	DURATION
Acute Coronary Thrombosis	Inst.
Due to	
Due to	
Other conditions: none	

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results: none performed
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: Milford H. Speaker M.D. (acting coroner)
Address: Elkton, Md. Date signed: Aug 6, 1945


AUG 9 1915
BUREAU U.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ Reg. Dist. No. 07937 96

1. PLACE OF DEATH:

County: CECIL

City or town: RURAL PERRYVILLE, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? NONE

Hospital, Institution, or street address where death occurred:
INTERSECTION OF U.S. HIGHWAYS 222 & 40

How long in hospital or institution? NONE

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: CONNECTICUT County:

City or town: BRIDGEPORT
(If outside city or town limits, write RURAL and give nearest town)

Street No. 442 VILLA AVENUE
(If rural, give LOCATION)

2.(a) If veteran, name war: WORLD WAR II ✓

3.(a) FULL NAME: BRUNDAGE, Robert Arnold

3.(b) Social Security Number: 899-38-03

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White US	Married

6.(b) Name of husband or wife: Wife-Ruth M. Brundage

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 29 July 1918

8. AGE: Years	Months	Days	If less than one day
27	--	18	....hrs. ....min.

9. Birthplace: Bridgeport, Connecticut
(Town, county, and state)

10. Usual occupation: U. S. Navy

11. Industry or business:

FATHER — 12. Name: Not Available

13. Birthplace:

MOTHER — 14. Maiden name: Not Available

15. Birthplace:

16. Informant: Not Available

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 8-20-45 (month) (day) (year)

Cemetery or crematory:

Location: Bishop & Son, Bridgeport, Conn.

18. Funeral director: Lee A. Patterson & Son

Address: Perryville, Md.

19. Aug 20 19 45 (Date received by registrar) Irene E. Dangler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 17 August 19 45 at 0155 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 17 August 19 45 to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Fracture, Simple, of Cervical Vertebra #2531 — DURATION: 5 minutes

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 17 August '45

Where did injury occur? Perryville, (City or town) Maryland (County) (State)

Injured at home, farm, industry, public place (where?) U. S. HIGHWAY #222 & #40

Means of injury: Auto accident Injured at work?

23. SIGNATURE: R. C. DODSON, MEDICAL EXAMINER M. D. or other

Address: RISING SUN, MD. CECIL COUNTY Date signed: 8-17-45

Medical Examiner Cecil County

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92nd)

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: Cecil
City or town: Port Deposit
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Port Deposit, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: N. Main
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Louisa J. Cain

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: William Cain deceased
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 9, 1861

8. AGE:

Years	Months	Days	If less than one day
84	7	21	..... hrs. ..... min.

9. Birthplace: Colora, Md. (Town, county, and state) Decided
10. Usual occupation: House work
11. Industry or business
FATHER 12. Name: Deitrich Hamm
13. Birthplace: Germany
MOTHER 14. Maiden name: Unknown
15. Birthplace: Germany
16. Informant: Albert L. Cain
Address: Port Deposit, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 2, 1945 (month) (day) (year)
Cemetery or crematory: West Nottingham
Location: Colora, Md. Rural
18. Funeral director: Lee A. Patterson & Son
Address: Perryville, Md.
19. Sept 2 19 45 Irma E. Daugherty Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 30 1945 at 6:30 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to Aug. 29 1945
and that I last saw h.er alive on August 29 1945
Immediate cause of death: Chronic Myocarditis — DURATION: 10 yrs
Due to:
Due to:
Other conditions: Chronic Endocarditis — DURATION: 10 yrs
(Include pregnancy within 3 months of death)
Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of injury: ..... Injured at work?

23. SIGNATURE: E. J. Benson M.D.
M. D. or other
Address: Port Deposit, Md. Date signed: 8-31-29

MARGIN TO BE RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07939

Reg. Diat. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

I. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred: Union Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Port Deposit

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Marvel Elwood Cain

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 28 1945

8. AGE: Years | Months | Days: 1 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Elkton Maryland (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER

12. Name: Benjamin Harrison Cain

13. Birthplace: Darlington, Md.

MOTHER

14. Maiden name: Pearline Boddy

15. Birthplace: Port Deposit, Md.

16. Informant: Pearline Cain

Address: Port Deposit, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 29 1945 (month) (day) (year)

Cemetery or crematory: Hosanna Cemetery

Location: Darlington Md.

18. Funeral director: Ezra C. Patterson & Son

Address: Perryville, Md.

19. Aug 29 1945 (Date rec'd by registrar) H. Ferguson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 29 1945, at 12-45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 28 1945 to Aug. 29 1945

and that I last saw him alive on Aug. 29 1945

Immediate cause of death	DURATION
Atelectasis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: R. L. Woodson M.D. M. D. or other

Address: Rising Sun, Md. Date signed 8-29-45

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(1)

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1192)

07940

CERTIFICATE OF DEATH ★

Reg. Diat. No. 96

1. PLACE OF DEATH:
County Cecil
City or town Port Deposit, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since birth
Hospital, institution, or street address where death occurred:
Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Cecil
City or town Port Deposit, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Cokesbury
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Geraldine Elaine Clark

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) February 26, 1945

8. AGE: Years	Months	Days	If less than one day
0	5	6	..... hrs. ..... min.

9. Birthplace Port Deposit, Cecil, Maryland
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name Hezekiah Clark
13. Birthplace Port Deposit, Maryland

MOTHER
14. Maiden name Mildred Jones
15. Birthplace Philadelphia, Penna.

16. Informant Hezekiah Clark
Address Port Deposit, Rural, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8 - 4 - 45 (month) (day) (year)
Cemetery or crematory Cokesbury
Location Port Deposit, Rural, Maryland

18. Funeral director Lee A. Patterson & Son
Address Box 157, Perryville, Maryland

19. 8/4/ 19 45 Irene E. Boyle Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2 19 45 at 7 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 27 19 45 to Aug 1 19 45
and that I last saw h[illegible] alive on Aug. 1 19 45

Immediate cause of death Uraemia - Colitis. — DURATION 5

Due to — DURATION

Due to — DURATION

Other conditions — DURATION

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE C. J. Patterson M D M. D. or other
Address Port Deposit Md Date signed 8-7-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

CERTIFICATE OF DEATH

07941 86

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Perryville, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? -----

Hospital, institution, or street address where death occurred: Perryville, Md. U.S. Highway #222 & #40

How long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Pennsylvania County:

City or town: Pittsburgh (If outside city or town limits, write RURAL and give nearest town)

Street No. 2419 Osgood Street (If rural, give LOCATION)

2.(a) If veteran, name war: World War II ✓

3. (a) FULL NAME: FORSTER, James Henry 924-78-52

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White US	Married

6.(b) Name of husband or wife: Wife Edna Forster

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 12, 1913

8. AGE: Years	Months	Days	If less than one day
32	0	5	hrs. min.

9. Birthplace: Pittsburgh, Pennsylvania (Town, county, and state) Allegheny County

10. Usual occupation: U. S. Navy

11. Industry or business:

FATHER — 12. Name: Not Available

13. Birthplace:

MOTHER — 14. Maiden name: Not Available

15. Birthplace:

16. Informant: U.S. Naval Hospital, Bainbridge Address: Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 8-21-45 (month) (day) (year)

Cemetery or crematory: Simons Funeral Home

Location: Pittsburgh, Pennsylvania

18. Funeral director: Lee A. Patterson & Son Address: Perryville, Md.

19. Aug 21 19 45 Irene E. Dough (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 17 August 19 45 at 0155 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 17 August 19 45 to 19

and that I last saw h alive on ----------- 19

	DURATION
Immediate cause of death: Fracture, Compound, Skull #2529	5 minutes
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause tn which death should he charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 17 August 1945

Where did injury occur? Perryville (City or town) Cecil (County) Maryland (State)

Injured at home, farm, industry, public place (where?) U.S. Highway 222 & 40

Means of injury: Auto accident Injured at work?

23. SIGNATURE: R. C. Dodson M.D. Medical Examiner Cecil County

R. C. DODSON, MEDICAL EXAMINER M. D. or other

Address: Rising Sun, Cecil Ctv. Date signed: 8/17/45

Evidence for addition of sex & color is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

07942

FILM No. G 97 AUG 31 1945

CERTIFICATE OF DEATH

★ Reg. Dist. No. 91

1. PLACE OF DEATH:

County Cecil

City or town Chesapeake City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Cecil

City or town Chesapeake City

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Archibald B. Foster

3.(b) Social Security Number 216-18-0299

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Jennie E. Foster

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 5 1885

8. AGE: Years	Months	Days	If less than one day
59	9	8	hrs. min.

9. Birthplace Chesapeake City Cecil Co. Md (Town, county, and state)

10. Usual occupation Machinist

11. Industry or business Boat Yard

FATHER 12. Name Charles A. Foster

13. Birthplace Md

MOTHER 14. Maiden name Laura Briggs

15. Birthplace Md

16. Informant Mrs Ritter

Address Chesapeake City Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 16 1945 (month) (day) (year)

Cemetery or crematory Bethel

Location Chesapeake City, Md.

18. Funeral director Jesse R. Lewis

Address North East, Md

19. Aug. 14 19 45 Mrs Ralph H Rees Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13 1945 at 7.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Drowned.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 8-13-45

Where did injury occur? Chesapeake City (City or town) Cecil (County) Md (State)

Injured at home, farm, industry, public place (where?) Chesapeake Canal

Means of injury Drowned. Injured at work?

23. SIGNATURE L. L. Dodson M.D. Medical Examiner for Cecil County

M. D. or other

Address Elkton Md Date signed 8-14-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Diat. No. 07943 94

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: North East

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: North East, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Samuel Edwin Harvey

3.(b) Social Security Number Cannot find card

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Edith E. Harvey

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 25, 1892

8. AGE: Years	Months	Days	If less than one day
53	5	3	hrs. min.

9. Birthplace: North East, Cecil Co., Md.
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER 12. Name: George W. Harvey

13. Birthplace: North East, Md.

MOTHER 14. Maiden name: Elizabeth A. Friday

15. Birthplace: Pa.

16. Informant: Edith E. Harvey

Address: North East, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 1, 1945. (month) (day) (year)

Cemetery or crematory: Methodist Cemetery

Location: North East, Md.

18. Funeral director: Ralph M. Reed

Address: Rising Sun, Md.

19. Aug 30 1945 (Date rec'd by registrar) Lois L. Evans Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 28 1945 at 11 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Coronary	
Due to: Thrombosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: R. LeDodson M.D. Medical Examiner Cecil County
M. D. or other

Address: Rising Sun Md Date signed: 8-29-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

★ 07944 Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton Rural.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Childhood

Hospital, institution, or street address where death occurred:

Elkton R.D. 1 Md

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Elkton Rural.

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.D. 1, Md

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William T. Holden.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 22 1862.

8. AGE: Years	Months	Days	If less than one day
82.	8.		..... hrs. ..... min.

9. Birthplace: Elkton Md.

(Town, county, and state)

10. Usual occupation: Retd Farmer.

11. Industry or business: Carpenter

FATHER — 12. Name: William W. Holden

FATHER — 13. Birthplace: Elkton R.D. Md

MOTHER — 14. Maiden name: Telethia Mahoney

MOTHER — 15. Birthplace: North East R.D. Md

16. Informant: Mrs. Charles Holden

Address: Elkton R.D. 1, Md

17. Burial — Date thereof: Aug 24/45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: North East Methodist

Location: North East Md

18. Funeral director: H.W. Pippin

Address: Elkton, Md.

19. Aug 24 19 45 — F R Evans, Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 21 19 45 at 3.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: R.L. Dodson Jr. M.D. Medical Examiner Cecil County

M. D. or other

Address: Beaugeur Md. Date signed: 8-21-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

07945

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: Cecil
City or town: Port Deposit Rural.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Port Deposit Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Ruth Ella Hughes.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Col	married

6.(b) Name of husband or wife: Elijah Hughes. 6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): Dec 16

8. AGE: Years	Months	Days	If less than one day
unknown			hrs. min.

9. Birthplace: North East Md. (Town, county, and state)
10. Usual occupation: House work
11. Industry or business
FATHER 12. Name: George Davis.
FATHER 13. Birthplace: Calvert Md.
MOTHER 14. Maiden name: unknown
MOTHER 15. Birthplace
16. Informant: Mary Hughes
Address: Port Deposit, Md. Rural
17. Burial (Burial, cremation, or removal. Which?) Date thereof: aug 20 1945 (month) (day) (year)
Cemetery or crematory: Cokesbury
Location: Port Deposit Md. Rural
18. Funeral director: Lee A. Patterson & Son
Address: Perryville, Md.
19. Aug 19 19 45 Irma E. Daugherty Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 18 19 45, at 6.10 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Chronic Myocarditis	
Due to: Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

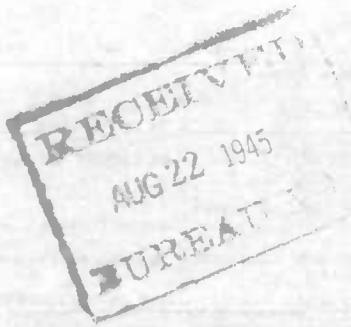
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. L. Dodson M.D. Medical Examiner for Cecil County
M. D. or other
Address: Rising Sun Md. Date signed: 8-16-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15


RECEIVED
AUG 22 1945
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

Reg. Dist. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Perryville Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Perryville Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Roswell Jackson Sr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Widowed

B.(b) Name of husband or wife: Laura M.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 17. 1857

8. AGE:

Years	Months	Days	If less than one day
88	6	—	..... hrs. ..... min.

9. Birthplace: Cecil Co. Md. (Town, county, and state)

10. Usual occupation: Laborer (Retired)

11. Industry or business: Pegura R.R.

FATHER 12. Name: Edward Jackson

13. Birthplace: Cecil Co., Md.

MOTHER 14. Maiden name: Caroline Watson

15. Birthplace: Cecil Co. Md.

16. Informant: Edward Jackson

Address: Perryville, Md. R.F.D. 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 19, 1945 (month) (day) (year)

Cemetery or crematory: Asbury

Location: Port Deposit, Md. Rural

18. Funeral director: Lee A. Patterson & Son

Address: Perryville, Md.

19. Aug. 19, 1945 (Date received by registrar) Irma E. Longbotham Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 17, 1945 at 2a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12, 1945, to Aug. 17, 1945

and that I last saw h... alive on July 31, 1945

Immediate cause of death: Gangrene

arteriosclerosis

DURATION: 1 day

Due to: Old age

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. J. Magraw. M. D. or other

Address: Perryville Md. Date signed: 8/19/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (467)

CERTIFICATE OF DEATH

07947

★ Reg. Dist. No. 96

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Charlestown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 32 years.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Charlestown.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William Evans Jackson

3.(b) Social Security Number:

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Jennie B Jackson (Deceased)
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Jan 11, 1870
8. AGE: Years: 75 Months: 6 Days: 29 If less than one day: ..... hrs. ..... min.
9. Birthplace: Cecil Co. Md. (Town, county, and state)
10. Usual occupation: Track Foreman
11. Industry or business: Penna. R.R.

FATHER
12. Name: William E. Jackson
13. Birthplace: Cecil Co. Md.

MOTHER
14. Maiden name: Laura J. Hitchcock
15. Birthplace: Cecil Co. Md.

16. Informant: Della Walstrum
Address: Charlestown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 12, 1945 (month) (day) (year)
Cemetery or crematory: Asbury
Location: Port Deposit, Md. Rural
18. Funeral director: Lee A. Patterson & Son
Address: Perryville, Md.

19. Aug 11 19.. (Date received by registrar) Irma E. Dempsey (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 9 1945, at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 25 1945 to Aug 9 1945 and that I last saw h.. alive on Aug. 7- 1945

Immediate cause of death: Carcinoma of the Liver — DURATION: 6 mo.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ..... Injured at work?

23. SIGNATURE: C Blevins M. D. or other
Address: North East Md. Date signed 8-10-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07948

CERTIFICATE OF DEATH

Reg. Diat. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton Rural

(If outside city or town limits, write RURAL and give nearest town)

How long te above place of death? 6 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Elkton Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R D 2

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Arnold Lee Johnston

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 22 1931

8. AGE:

Years	Months	Days	If less than one day
13	7	21	hrs. min.

9. Birthplace: Crucesville W. Va. (Town, county, and state)

10. Usual occupation: Child.

11. Industry or business:

FATHER — 12. Name: John W. Johnston

FATHER — 13. Birthplace: Crucesville W. Va.

MOTHER — 14. Maiden name: Dora Parlier Hinkle

MOTHER — 15. Birthplace: Hunting Ground W. Va.

16. Informant: John W. Johnston

Address: Elkton R.D. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 7 1945 (month) (day) (year)

Cemetery or crematory: Elkton Cemetery

Location: Elkton Md

18. Funeral director: H. A. Tippin

Address: Elkton, Maryland

19. Aug 6 1945 (Date rec'd by registrar) H R Evans Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 3 1945, at 7:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Struck by Lightening	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 8-3-45

Where did injury occur? Elkton R.D. Cecil Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Home.

Means of injury: Lightening Injured at work?

23. SIGNATURE: P. L. Dodson M.D. Medical Examiner Cecil County

M. D. or other

Address: Elkton Md Date signed: 8-3-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Md)

CERTIFICATE OF DEATH

07949

Reg. Dist. No. 9 V

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Days.

Hospital, institution, or street address where death occurred: Union Hospital

How long in hospital or institution? 3 Days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: North East Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Lewis Jones. LEWIS ELWOOD JONES

3. (b) Social Security Number None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 20 1888.

8. AGE:

Years	Months	Days	If less than one day
57.	5	2.	..... hrs. ..... min.

9. Birthplace: North East Md. (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: Hiram Jones.

13. Birthplace: North East Md.

MOTHER — 14. Maiden name: Elizabeth Hughes

15. Birthplace: North East Md.

16. Informant: Hiram Jones.

Address: North East Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Aug 26 '45 (month) (day) (year)

Cemetery or crematory: Methodist

Location: North East Md.

18. Funeral director: Joseph R. Shaum

Address: North East, Md.

19. Aug 25 1945 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 22 1945 at 9.00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Pneumonia.	
Due to: Synal cord.	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 8/19-45

Where did injury occur? North East Cecil Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home.

Means of injury: Fell down steps Injured at work?

23. SIGNATURE: R L Hodgden M.D. Medical Examiner Cecil County

Address: Rising Sun Md. M. D. or other Date signed 8-22-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

Reg. Dist. No. 11795 (6)2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Union Hosp.

How long in hospital or institution? Union — 2 — months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Cecil

City or town: Elkton R no 4

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3. (a) FULL NAME: Robert Royal Langelene

3. (b) Social Security Number: 221-14-8062

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Doris Eydenora Langelene

6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): June 1 1894

8. AGE: Years: 51 Months: 2 Days: 10 If less than one day: ...hrs. ...min.

9. Birthplace: Union, Cecil Co. Md (Town, county, and state)

10. Usual occupation: Rigger

11. Industry or business: Ship Yard

FATHER — 12. Name: Robert Chadwick Langelene

FATHER — 13. Birthplace: Md

MOTHER — 14. Maiden name: Anna Mary Scarborough

MOTHER — 15. Birthplace: Md

16. Informant: Mrs Robert Royal Langelene

Address: Elkton R 4 Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 15 '45 (month) (day) (year)

Cemetery or crematory: Rosebank

Location: Calvert

18. Funeral director: Joseph B Frazer

Address: North East, Md

19. Aug 15 19 45 (Date rec'd by registrar) H B Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 11, 1945, at 12.30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1945 to Aug 11 1945 and that I last saw him alive on Aug 11, 1945

Immediate cause of death	DURATION
Pulmonary edema	
Due to: Carcinoma of Lung	
Due to: Carcinoma Rt. Breast	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Biopsy - Carcinoma Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. A. Cumbull M.D. M. D. or other

Address: Elkton Md Date signed: Aug 14 45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 53

CERTIFICATE OF DEATH

07951

Reg. Dist. No. 93

1. PLACE OF DEATH:

County: Cecil

City or town: Port Deposit Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Port Deposit Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Agnes E. Linton

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 7 1857

8. AGE:

Years	Months	Days	If less than one day
88	6	8	..... hrs. ..... min.

9. Birthplace: Philadelphia Pa.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER — 12. Name: Thomas Linton

FATHER — 13. Birthplace: Philadelphia Pa.

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Unknown

16. Informant: Clarence Kelly

Address: Port Deposit Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 19 1945 (month) (day) (year)

Cemetery or crematory: Mt Hope Pa.

Location: Quarryville Pa.

18. Funeral director: J. E. Lyon

Address: Port Deposit Md.

19. Aug 17 1945 (Date received by registrar) L. M. Worthington Registrar

Permit issued 8-17-45

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 16 1945, at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1945 to August 16 1945

and that I last saw her alive on August 7 1945

Immediate cause of death: Carcinoma of Face & Breast — General Metastasis

Due to: Primary in Face

Due to: secondary in Breast & Lungs

Other conditions

(Include pregnancy within 3 months of death)

DURATION
8 yrs

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: C. J. Johnson, M.D.
M. D. or other

Address: Port Deposit Md. Date signed 8/17/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

Bureau 07952

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil Co. Md.
City or town: Port Deposit
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 months
Hospital, Institution, or street address where death occurred: 46 N. Main St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: New York County:
City or town: Rosedale, L. I.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 232-12-143 ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Linton

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: John R. Linton
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 12, 1867

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
78 yrs.	5	26		

9. Birthplace: New York City N.Y.
(Town, county, and state)
10. Usual occupation: Houde-wife
11. Industry or business

FATHER
12. Name: John Dougherty
13. Birthplace: Ireland

MOTHER
14. Maiden name: Mary Morrisey
15. Birthplace: Ireland

16. Informant: Mrs. John S. Linton
Address: 232-12-143rd. Ave
17. Removal & Burial (Burial, cremation, or removal—Which?) Date thereof: Aug. 11, 1945 (month) (day) (year)
Cemetery or crematory: Calvary
Location: Brooklyn, New York
18. Funeral director: Lee A. Patteson & Son
Address: Perryville, Md.
19. Aug. 8 1945 Irene E. Daughty
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 8 - 1945, at 9.30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 5 - 1945, to Aug 7 1945
and that I last saw ... alive on Aug 7 - 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	week
Due to	
Due to	
Other conditions: Paralysis right side	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: E. J. Broom M.D.
M. D. or other
Address: Brt Street
Date signed: 8-8-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07953

Reg. Dist. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Veterans Administration, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 mo. 4 da.

Hospital, Institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County: -

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1135 - 10th St., N.W., Wash. D.C.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I ✓

3.(a) FULL NAME: MANCE, Montgomery

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Essie ? Mance

6.(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): October 6, 1898

8. AGE: Years	Months	Days	If less than one day
46	10	15	- hrs. - min.

9. Birthplace: Greenwood, S.C.
(Town, county, and state)

10. Usual occupation: Truck Driver

11. Industry or business: -

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 8-22-45 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Va.

18. Funeral director: Pennington & Son
Address: Havre de Grace, Md.

19. Aug 22 1945 (Date rec'd by registrar) Irene E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 21 1945, at 4:20A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 17 1945, to August 21 1945 and that I last saw him alive on August 21 1945

Immediate cause of death	DURATION
Cerebral Thrombosis	Immediate
Due to: Cerebral Hemorrhage	2½ months
Due to:	
Other conditions: Psychosis with C.N.S. Lues, Meningo-encephalitic type	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: -

Date of op.: -

Autopsy results: Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: - Date of: -

Where did injury occur? - (City or town) - (County) - (State)

Injured at home, farm, industry, public place (where?): -

Means of injury: - Injured at work? -

23. SIGNATURE: A.E. Trollinger

Address: A.E. TROLLINGER, Lt.Col., M.C. Clinical Director, Veterans Administration, Perry Point, Md. Date signed: 8-22-45

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Cecil

Veterans Administration, Perry Point, Md. — D.C. —

7 mo. 4 ds. Washington

Veterans Administration, Perry Point, Md. 1135 - 10th St., N.W., Wash. D.C.

Same as above NW I

MANUEL Montgomery

Male Negro Married August 21 45 4:30A.

Esther Pearce Unknown January 17 45 August 21 45

October 6, 1898 1m August 21 45

Cerebral Thrombosis Immediate

46 10 15 — — Cerebral Hemorrhage 3½ months

Greenwood, S.C.

Truck Driver

—

Psychosis with C.N.S.

Lues, Meningo-encephalitic type Unknown

Unknown

Unknown

Unknown

Unknown

Hospital Records

Not performed

Veterans Administration, Perry Point, Md.

Removal 8-22-45

Arlington National Cemetery

Arlington, Va.

Pennington & Son

Havre de Grace, Md.

A.E. TROLLINGER Lt.Col., M.C. Clinical Director, Veterans Administration 8-22-45

Perry Point, Md.

RECEIVED AUG 24 1945 BUREAU

07954

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Perry Point, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs. 1 mo. 10 da.

Hospital, Institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: -

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 509 Lyndhurst St.
(If rural, give LOCATION)

2.(a) If veteran, name war: W.W. I

3.(a) FULL NAME: MESSNER, John J.

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: none

6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): December 27, 1895

8. AGE: Years	Months	Days	If less than one day
49	7	12	- hrs. - min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: -

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden name: "
15. Birthplace: "

16. Informant: Hospital Records

Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 8-10-45 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Md.

18. Funeral director: Pennington & Son, Havre de Grace,

Address: Pennington & Son, Md.

19. Aug. 10 19 45 (Date received by registrar) Irene E. Dangfield Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 8 1945 at 9:20P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 29 1925 to August 8 1945 and that I last saw him alive on August 8 1945

Immediate cause of death	DURATION
Occlusion, coronary	Immediate
/// Pneumonia, lobar, left	Undetermined
Due to:	
Other conditions: Psychosis with mental deficiency	Over 20 years

(Include pregnancy within 3 months of death)

Major findings of operations: -

Date of op.: -

Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: - Date of: -

Where did injury occur? - (City or town) - (County) - (State)

Injured at home, farm, industry, public place (where?): -

Means of injury: - Injured at work? -

23. SIGNATURE: A. E. TROLLINGER, Lt. Col., M.C., Clinical Director

Address: Director, Veterans Administration, PERRY POINT, MD. Signed 8-9-45

Evidence for change of age is shown on [illegible] G 98 SEP 13 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07955

Reg. Dist. No. 95

1. PLACE OF DEATH

County: Cecil

City or town: Rising Sun

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mo

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Farmington R F D

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rising Sun

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Bernard Evans Murdock

3.(b) Social Security Number 217-18-9843

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of ~~husband~~ or wife: Mary Murdock

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Oct 30, 1907

8. AGE: Years	Months	Days	If less than one day
37 -38	9	29	..... hrs. ..... min.

9. Birthplace: Christiansburg, Va

(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farm

FATHER

12. Name: Samuel Murdock

13. Birthplace: Christiansburg, Va.

MOTHER

14. Maiden name: Celia D. Sweeney

15. Birthplace: Christiansburg Va

16. Informant: Mary Murdock

Address: Rising Sun

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 2, 1945 (month) (day) (year)

Cemetery or crematory: Hopewell Cemetary

Location: Port Deposit, Md.

18. Funeral director: Ralph M Reed

Address: Rising Sun Md.

19. Aug 31 19 45 [illegible] Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 29 1945, at 9:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/26 1945, to 8/29 1945

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Paralysis of Respiration	
Due to: Hemorrhage in brain.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: R L Dodson MD

M. D. or other

Address: Rising Sun Md. Date signed: 9-3-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (57-2)

CERTIFICATE OF DEATH

07955

Reg. Diat. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Perryville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Perryville
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Mary J. Notarcola

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 10, 1945

8. AGE: Years — Months — Days 1 — If less than one day: hrs. min.

8. Birthplace: Perryville Cecil, Md.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER 12. Name: Gaetano Notarcola

13. Birthplace: Italy

MOTHER 14. Maiden name: Lola Raphaelli

15. Birthplace: Italy.

18. Informant: Lola Notarcola

Address: Perryville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 11 1945 (month) (day) (year)

Cemetery or crematory: Mt. Ernest

Location: Havre de Grace, Md.

18. Funeral director: Lee A. Patterson & Son

Address: Perryville, Md.

19. Aug. 11 19 45 Inez E. Smith
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 11 19 45, at 5A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 10 19 45, to Aug 11 19 45

and that I last saw h[illegible] alive on Aug 10 19 45

Immediate cause of death	DURATION
Non Union Foramen Ovale	
Imperfect Foetal Development	1da
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. F. Magraw M. D. other

Address: Perryville Md. Date signed: 8/11/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9)

CERTIFICATE OF DEATH

07957

★ Reg. Dist. No. 94

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: North East Cecil Co
City or town: North East Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Cecil
City or town: North East Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Ralph Leonard Parrett

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): March 17 1945

8. AGE: Years	Months	Days	If less than one day
1	4	16	____ hrs. ____ min.

9. Birthplace: Elkton, Cecil, Md (Town, county, and state)
10. Usual occupation: —
11. Industry or business: —

FATHER
12. Name: Elmer L. Parrett
13. Birthplace: North East Md

MOTHER
14. Maiden name: Elizabeth R. Laird
15. Birthplace: Marysville, Md

16. Informant: Elmer L. Parrett
Address: NorthEast, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 5 1945 (month) (day) (year)
Cemetery or crematory: Methodist
Location: North East Md
18. Funeral director: Joseph R. Graves
Address: North East, Md

19. 8-4-45 (Date rec'd by registrar) Lucia E. Evans Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 2 1945, at 6:20 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 25 1945, to Aug 2 1945
and that I last saw him alive on Aug 2 1945

	DURATION
Immediate cause of death: Whooping Cough	10 days
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. ____
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: C B Collins M. D. or other
Address: North East, Md Date signed: 8-4-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07958

CERTIFICATE OF DEATH

Reg. Dist. No. 9C

1. PLACE OF DEATH:

County: CECIL

City or town: Perryville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Georgia County:

City or town: Atlanta
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 72 Anthone St.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War II ✓

3. (a) FULL NAME: PEAL, Harmon Buford

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	Married

6.(b) Name of husband or wife: Mrs. Voe Anne Peal

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 3-29-16

8. AGE: Years	Months	Days	If less than one day
29	4	19	hrs. min.

9. Birthplace: Rome, Georgia
(Town, county, and state)

10. Usual occupation: U. S. Navy

11. Industry or business

FATHER — 12. Name: Not Available

13. Birthplace

MOTHER — 14. Maiden name: Not Available

15. Birthplace

16. Informant: Records Office, U.S. Naval Hosp

Address: Bainbridge, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof Aug 22 1945 (month) (day) (year)

Cemetery or crematory: National

Location: Marietta, Georgia

18. Funeral director: Lee A. Patterson & Son

Address: Perryville, Md.

19. Aug. 22 19 45 (Date rec'd by registrar) Irene E. Daughaday Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 17 August 19 45, at 0155 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 17 August 1945, to 19

and that I last saw h alive on --- 19

Immediate cause of death	DURATION
FRACTURE, SKULL, COMPOUND #2529	5 minutes
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 17 Aug. 1945

Where did injury occur? Perryville, (City or town) (County) Maryland (State)

Injured at home, farm, industry, public place (where?) Highway

Means of injury: Auto accident Injured at work?

23. SIGNATURE: R. C. Dodson, Medical Examiner
M. D. or other

Address: Rising Sun, Md. Cecil Co. Date signed: 8-17-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17-C)

CERTIFICATE OF DEATH

07959

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: CECIL

City or town: Perryville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ---

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Ohio County: Uyahoga

City or town: Cleveland
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War II

3.(a) FULL NAME: PICKERELL, Gordon Chesleigh, Jr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age: ....years

7. Birth date of deceased (mo., day, yr.): December 17, 1926

8. AGE: Years	Months	Days	If less than one day
18	8	0	....hrs. ....min.

9. Birthplace: Cleveland, Ohio
(Town, county, and state)

10. Usual occupation: U. S. Navy

11. Industry or business: Not Available

FATHER
12. Name: Gordon C. Pickerell Sr.
13. Birthplace: Not Known

MOTHER
14. Maiden name: Not Known
15. Birthplace: Not Known

16. Informant: Records Office, U.S. Naval Hosp
Address: Bainbridge, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 27 1945 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Ft. Meyer, Va.

18. Funeral director: Lee A. Patterson & Son

Address: Perryville, Md.

19. Aug 27 19 45 (Date rec'd by registrar) Irene E. Dunphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 17 August 45 at 0155 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 17 August 19 45, to ....19....

and that I last saw h... alive on ....19....

Immediate cause of death	DURATION
INJURIES, MULTIPLE, EXTREME, CHEST AND ABDOMEN	
Due to: INJURIES, MULTIPLE, EXTREME, CHEST AND ABDOMEN	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

....Date of op.....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 17 August 45

Where did injury occur? Perryville (City or town) Cecil (County) Maryland (State)

Injured at home, farm, industry, public place (where?): U.S. Highway 222 & 40

Means of injury: Auto Accident Injured at work?

23. SIGNATURE: R. C. Dodson, Medical Examiner M. D. or other

Address: Rising Sun, Md. Cecil Co. Date signed: 8-17-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

07960

CERTIFICATE OF DEATH

Reg. Dist. No. 91

1. PLACE OF DEATH:

County: Cecil

City or town: Chesapeake City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: maryland County: Cecil

City or town: Chesapeake City

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Helen Pyle.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	white	married

6.(b) Name of husband or wife: Wm Pyle

6.(c) If alive, give age: 37 years

7. Birth date of deceased (mo., day, yr.): Sept 6 1912

8. AGE: Years	Months	Days	If less than one day
32	11	7	...hrs. ...min.

9. Birthplace: Galena Kent md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: James Martel Dill

FATHER 13. Birthplace: Church Hill Md

MOTHER 14. Maiden name: Katie Moore

MOTHER 15. Birthplace: Millington. Md

16. Informant: James M Dill

Address: Middletown Del RD 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 17 1945 (month) (day) (year)

Cemetery or crematory: Masseys Cemetery

Location: Masseys Maryland

18. Funeral director: H. W. Pippin

Address: Elkton Md

19. Aug 14th 1945 (Date rec'd by registrar) Wm Ralph Hall Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 13. 1945 at 7.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...

and that I last saw h...alive on ...19...

Immediate cause of death	DURATION
Drowned.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 8/13-45

Where did injury occur? Chesapeake City Cecil md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Chesapeake Canal

Means of injury: Drowning Injured at work?

23. SIGNATURE: R E Dodson M.D. Medical Examiner for Cecil County

Address: Rising Sun Md. M. D. or other

Date signed: 8/13-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Morrison 7961 92

★ Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 hr
Hospital, Institution, or street address where death occurred: Union Hospital
How long in hospital or institution? 1 hr

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No.: East Main St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Idella M. Racine

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John Racine
6.(c) If alive, give age: – years

7. Birth date of deceased (mo., day, yr.): Sept 30 1871

8. AGE: Years	Months	Days	If less than one day
~~74~~ 73			..... hrs. ..... min.

9. Birthplace: Elkton Cecil Md RD 1
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Robert Jackson
13. Birthplace: Penn

MOTHER
14. Maiden name: Anna Jackson
15. Birthplace: Elkton Md R D

16. Informant: Lula Jackson
Address: Balto Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 5 1945 (month) (day) (year)
Cemetery or crematory: Elkton cemetery
Location: Elkton Md

18. Funeral director: H. W. Lippincott
Address: Elkton Md

19. Aug 4 1945 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 1 1945, at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 1945 to Aug 1 1945 and that I last saw her alive on Aug 1, 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	2 hrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: N. T. Morrison, M. D. (M. D. or other)
Address: Elkton, Md Date signed: 8-4-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30-D

07962

CERTIFICATE OF DEATH

★ Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Veterans Administration, Perry Point, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:

Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: -

City or town: Spencer Street, Baltimore,

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Spencer Street

(If rural, give LOCATION)

2.(a) If veteran, name war: W.W. I

3. (a) FULL NAME: REDER, Horace M.

3. (b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife: Single

6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): Day & month unknown 1894

8. AGE: Years	Months	Days	If less than one day
51	-	-	- hrs. - min.

9. Birthplace: Prince George Co., Md.

(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: -

FATHER — 12. Name: Unknown

13. Birthplace: Unknown

MOTHER — 14. Maiden name: Unknown

15. Birthplace: Unknown

18. Informant: Hospital records

Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 8-25-45 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Md.

18. Funeral director: Pennington & Son,

Address: Havre de Grace, Md.

19. Aug. 25 19 45 (Date rec'd by registrar) Irma E. Sample Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 22 19 45 at 5:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 20 19 45 to August 22 19 45 and that I last saw him alive on August 22 19 45

Immediate cause of death	DURATION
Aneurysm, Abdominal, rupture of	Undetermined
Due to	
Due to	
Other conditions: Arteriosclerosis, generalized and coronary	Undetermined

(Include pregnancy within 3 months of death)

Major findings of operations: -

Date of op.: -

Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: - Date of: -

Where did injury occur? (City or town) - (County) - (State) -

Injured at home, farm, industry, public place (where?): -

Means of injury: - Injured at work? -

23. SIGNATURE: O. E. Hollinger

O. E. HOLLINGER, Lt. Col., M.C. Clinical Director, Veterans Administration

Address: Perry Point, Md. Date signed: 8-22-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07963

CERTIFICATE OF DEATH

★ Reg. Dist. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: U.S. Naval Training Center, Bainbridge (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mos.

Hospital, institution, or street address where death occurred: USNTC, Bainbridge, Maryland

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Michigan County: Kent

City or town: 308 Crescent St., N.E., Grand Rapids, Mich. (If outside city or town limits, write RURAL and give nearest)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: World War #2 ✓

3.(a) FULL NAME: RISTE, Gerhard Nathaniel

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Harman Riste

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 3-23-98

8. AGE: Years	Months	Days	If less than one day
47	4	17	hrs. min.

9. Birthplace: Decorah, Iowa (Town, county, and state)

10. Usual occupation: Special Agent-Mass. Life Ins. Co.

11. Industry or business: Br. Office, Grand Rapids, Mich.

FATHER — 12. Name: Nils (n) Riste

FATHER — 13. Birthplace: Norway

MOTHER — 14. Maiden name: Kari Jacobsen

MOTHER — 15. Birthplace: Norway

16. Informant: Wife

Address: Qts. Q, USNTC, Bainbridge, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Aug. 12, 1945 (month) (day) (year)

Cemetery or crematory: Grand Rapids, Mich.

Location: Grand Rapids, Mich.

18. Funeral director: Lee A. Patterson & Son

Address: Perryville, Md.

19. Aug. 14, 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 10, 1945, at 7 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..., 19..., to ..., 19...

and that I last saw him alive on 10 August, 1945

Immediate cause of death	DURATION
Coronary Heart Disease, Arteriosclerotic	
Due to: Arteriosclerosis, General	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Confirms clinical diagnosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: R. W. Murray, Capt. (MC) USNR. M. D. or other

Address: NTC, Bainbridge, Md. Date signed: 8/11/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-a)

CERTIFICATE OF DEATH

07964

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days.
Hospital, Institution, or street address where death occurred: 5 days. Union Hosp.
How long in hospital or institution? 5 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pa. County: Chester
City or town: Eddystone
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1240 - 12th.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME Lawrence Rockett.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Single.

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.) July 21-1929.

8. AGE: Years	Months	Days	If less than one day
16.		13	hrs. min.

9. Birthplace: Chester Pa. (Town, county, and state)
10. Usual occupation: Fellow Boy.
11. Industry or business: Philadelphia Pa.
FATHER 12. Name: Frank L. Rockett.
13. Birthplace:
MOTHER 14. Maiden name: Mary J. Reilan
15. Birthplace: Chester Pa
16. Informant: Joseph Rockett
Address: 1240 12 west Eddystone Pa
17. Transfer removed (Burial, cremation, or removal. Which?) Date thereof: Aug 11 1945 (month) (day) (year)
Cemetery or crematory: Chester Cemetery
Location: Chester Pa
18. Funeral director: H W Pepper
Address: Exton Pa
19. Aug 9 1945 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 8 1945, at 1210 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Dislocated 5th Cervical	
Due to: Fracture	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 8-3-45
Where did injury occur? Haines Point Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Boxer
Means of injury: Drowning Injured at work?

23. SIGNATURE: R C Dodson M.D. Medical Examiner for Cecil County
M. D. or other
Address: Rising Sun Md Date signed: 8-8-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92)

07965

CERTIFICATE OF DEATH

Reg. Diat. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 days
Hospital, Institution, or street address where death occurred: Union Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No. 182 Hollingsworth near on
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Ida Saddler.

3. (b) Social Security Number

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
F.	White	married

8.(b) Name of husband or wife: George D. Saddler
8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mch 3 1893

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
52	5	3		

9. Birthplace: Dorwood W Va
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: George Canterbury
13. Birthplace: Dorwood W Va

MOTHER
14. Maiden name: Lockey Elkins W Va
15. Birthplace: W Va

16. Informant: George D Saddler
Address: Elkton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 10 1945 (month) (day) (year)
Cemetery or crematory: Elkton Cemetery
Location: Elkton Md

18. Funeral director: H. W. Pippin
Address: Elkton. Md

19. Aug 9 1945 (Date rec'd by registrar) F R Fraser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 6 1945 at 4.25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-19 1945, to Aug 6 1945
and that I last saw her alive on Aug 6 1945

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to Mitral Dropsy.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. L. Dodson M.D. M. D. or other
Address: Rear 9 Bush St. Date signed: 8/6-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8a)

CERTIFICATE OF DEATH

07966

★ Reg. Diat. No. 94

1. PLACE OF DEATH:

County: Cecil

City or town: Charlestown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Cecil

City or town: Charlestown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Carrie E Smith

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Stanley M. Smith

6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): Jan 22 - 1889

8. AGE:

Years	Months	Days	If less than one day
56	6	10	...hrs. ...min.

8. Birthplace: Blue Ball Cecil Co. Md
(Town, county, and state)

10. Usual occupation: —

11. Industry or business

FATHER — 12. Name: George J. DeMond
13. Birthplace: Md

MOTHER — 14. Maiden name: Elizabeth Hall
15. Birthplace: Md

16. Informant: Stanley M. Smith
Address: Charlestown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 5 1945 (month) (day) (year)

Cemetery or crematory: Rosebank

Location: Calvert. Md

18. Funeral director: Joseph R Leary

Address

19. 8-4 1945 (Date rec'd by registrar) Lida E. Cerna Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 2 1945 at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug- 2 1945 to Aug 2 1945 and that I last saw her alive on Aug 2 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 day
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ... Injured at work?

23. SIGNATURE: C. B. Cairns M. D. or other

Address: North East Md Date signed: 8-4-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07967

Reg. Dist. No. 96

1. PLACE OF DEATH:
County Cecil
City or town Perry Point, Md. (Veterans Administration)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year 24 days
Hospital, Institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.
How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Long Island, N.Y. County Nassau
City or town Garden City Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 69 Broadway
(If rural, give LOCATION)
2.(a) If veteran, name war W.W. I.

3.(a) FULL NAME: STAPLES, Gertrude Ada (Mrs.)

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Douglas F. Staples
6.(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): September 15, 1882

8. AGE: Years	Months	Days	If less than one day
62	10	18	- hrs. - min.

9. Birthplace: Brooklyn, N.Y.
(Town, county, and state)
10. Usual occupation: Nurse
11. Industry or business: -

FATHER
12. Name: John Morgan MacIntyre
13. Birthplace: New York City

MOTHER
14. Maiden name: Mary Jane DePew
15. Birthplace: New York City

16. Informant: Hospital Records
Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 8-3-45 (month) (day) (year)
Cemetery or crematory: Long Island National Cemetery
Location: Pine Lawn, L.I., New York

18. Funeral director: Pennington & Son
Address: Havre de Grace, Md.

19. Aug. 3 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 2 1945 at 5:38 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 7 1944, to August 2 1945 and that I last saw her alive on August 2 1945

Immediate cause of death	DURATION
Myocarditis, chronic	Over 2 years
Due to: General Arteriosclerosis	Over 2 years
Due to:	
Other conditions: Psychosis with cerebral arteriosclerosis	Over 2 years

(Include pregnancy within 3 months of death)

Major findings of operations: -
Date of op. -
Autopsy results: Not performed
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide - Date of -
Where did injury occur? - (City or town) - (County) - (State)
Injured at home, farm, industry, public place (where?) -
Means of injury - Injured at work? -

23. SIGNATURE: A.E. TROLLINGER Lt.Col., M.C.
Clinical Director.
M.D. or other
Address: Perry Point, Md. Date signed 8-3-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15